Letters to the Journal

Letters are welcomed and will be published as space permits. Like other material submitted for publication, they should be typewritten, double-spaced, should be of reasonable length, and will be subject to the usual editing.

Views expressed in Letters to the Journal are those of the writers concerned and are NOT to be interpreted as the opinions of The Canadian Medical Association or of the editors.

PROTECTION OF RENAL FUNCTION

To the Editor:

I read and enjoyed the excellent article "Protection of Renal Function during Surgery of the Abdominal Aorta" by Drs. R. J. Baird, W. B. Firor and H. W. K. Barr in the Journal issue of October 5 (*Canad. Med. Ass. J.*, 89: 705, 1963).

In the Discussion, an article by Boba and Landmesser in the year 1961 is quoted to explain renal shut-down during hemorrhage and trauma.

I was reminded, however, of a lecture given in about 1947 to the University of Toronto by Dr. B. Houssay. He demonstrated by microradiophotographs that arteriovenous shunts in the renal medulla would short-circuit blood from reaching the renal cortex in rabbits traumatized by various methods.

Minimizing trauma in their patients by the skill the authors have demonstrated, including maintenance of blood volume, and rapid, sharp diagnoses, is certainly a major factor in their good results.

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MAST CELL DISEASE

To the Editor:

In a recent issue (*Canad. Med. Ass. J.*, 89: 770, 1963) Rabinovich and Ley reported a very interesting case of systemic mast cell disease proved by skin and bone biopsies. The first Canadian case, reported in 1957 by MacDonald and Pierce from the Royal Victoria Hospital, Montreal (*J. Canad. Ass. Radiol.*, 8: 15, 1957), was a woman 51 years of age who showed the typical rash of Nettleship's disease and also had bone lesions. As far as I know, there are three other Canadian cases (Toronto General Hospital).

I would like to report a sixth Canadian case which I presented in June 1963 at the Annual Meeting of the Canadian Association of Pathologists and also at the Annual Meeting of the Quebec Association of Laboratory Physicians, in Montreal in September 1963.

My case is that of a 27-year-old white man who came to the hospital in October 1962 complaining of epigastric pain, loss of appetite, weight loss, enlargement of the abdomen and ankle edema. A macular rash, reddish brown or brown was present; this had appeared at the age of six months. There was no pruritus. Darier's sign was positive. Physical examination also revealed an enlarged liver and moderately enlarged lymph nodes. Laboratory examination disclosed evidence of liver dysfunction in the form of elevated gamma globulin and decreased albumin levels, elevated alkaline phosphatase, an elevated thymol turbidity, and a prolonged prothrombin time; a high sedimentation rate, hypocalcemia, hypocholesterolemia, and a blood picture compatible with myelofibrosis. Radiographs of the skeleton revealed generalized osteosclerosis. The urinary content of histamine was sharply increased. Biopsies of skin, liver, lymph nodes and bone revealed a typical mast-cell infiltration.

The patient was discharged after a 15-day stay in hospital, and received symptomatic treatment. He was seen occasionally at our cancer clinic. His condition did not improve. At the end of June 1963 he died suddenly after a brief stay in another hospital. Permission for autopsy was granted. Postmortem examination revealed a generalized peritonitis secondary to a perforated jejunal ulcer, three acute jejunal ulcers which had not perforated, an enlarged spleen, liver and lymph nodes, thickening of the bones, and cachexia. Microscopic examination revealed a systemic mast cell disease involving the liver, the spleen, the lymph nodes, the bones and the skin (mast cell reticulosis) and liver and splenic cirrhosis with hemosiderosis. This case has been registered with the Canadian Tumour Registry (C.T.R. No. 8023).

As far as I know, this is the first autopsy case of systemic mast cell disease in Canada and the eleventh one in the world literature (since Ellis' report in 1949).

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INTERNATIONAL MEDICAL AID

To the Editor:

Dr. Florence J. Murray's letter (*Canad. Med. Ass. J.*, 89: 727, 1963) on the subject of international medical aid was a welcome commentary from one obviously qualified to pass an opinion. Although Dr. Murray says little about her own work, the fact that her address is the Mission to Lepers in South Korea, and that she has spent 40 years doing medical work in the Far East gives her an experience which few of us possess.

At the same time I would like to correct what is apparently a misapprehension on her part with regard to the projected staffing of a hospital in the Andes by Canadian doctors and nurses. Dr. Murray assumes that this hospital will be built under Canadian auspices, and such is not the case. The hospital in question is being built by the Peruvian authorities, and will be staffed by Peruvian medical personnel. The aim of Canadian International Medical Aid in this instance is to provide the local staff with a certain measure of advanced training so that they might make better use of the new hospital facilities being provided to them by their own government. The medical staff of the region is made up of 65 doctors whose training is adequate by local standards, but lacking at the level required to run a modern hospital by modern standards. The effort of the Canadian contingent would therefore be directed in part to providing what would amount to training to local personnel who, because of financial and other limitations, cannot hope to take such training out of the country. Within a concept of this type the commitment of Canadian personnel to a period of service of one year would fulfil many of the requirements not present within another type of medical mission.

I am in complete agreement with Dr. Murray that the initiation of medical assistance which is turned over prematurely to those unprepared to sustain it, is both